



Tuberculosis Contact Investigation Form

Submitted By: _____

Date: _____

Case							Contact									
Name: (last) (first) (MI) (also known as)							Priority of exposed contact					Contact Investigation			Contact Risk Factors (Mark Y =Yes or N = No in chart below)	
DOB: Age: RVCT:							(please refer to CI Data Dictionary for definitions) <input type="checkbox"/> 1. Smear positive or cavitory chest x-ray <input type="checkbox"/> 2. Smear negative <input type="checkbox"/> 3. Suspect case					Date Identified: _____ Date Interviewed: _____ Date of Evaluation: _____			1. Household 2. Less than 5 years of age 3. Contact has medical risk factor (i.e. HIV) 4. Exposed during medical procedure 5. Exposed congregate Setting 6. Exceeds duration environment limits 7. CXR consistent with previous TB 8. 5 - 15 years of age	
Morbidity Date:																
County: Comments:																
Type: <input type="checkbox"/> Pulmonary <input type="checkbox"/> Non Pulmonary CXR Results: <input type="checkbox"/> Cavitory <input type="checkbox"/> Noncavitory																
Full Name of Contact	Date of Birth	*Exposure category	Household	< 5 years	Med risk	Medical exposure	Cong Set	Enviro limits	CXR- prev	5 – 15 years	PPD Results		Chest X-Ray	Treatment of LTBI	***Completion Date or Discontinued Due to (**see below):	
											**Prior Positive (*See below)	Current	8 – 10 week retest			
1.												Date: _____ mm: _____	Date: _____ mm: _____	Date: _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	<input type="checkbox"/> Yes Date: _____ Drug (s) _____ <input type="checkbox"/> No Reason: _____	
2.												Date: _____ mm: _____	Date: _____ mm: _____	Date: _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	<input type="checkbox"/> Yes Date: _____ Drug (s) _____ <input type="checkbox"/> No Reason: _____	
3.												Date: _____ mm: _____	Date: _____ mm: _____	Date: _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	<input type="checkbox"/> Yes Date: _____ Drug (s) _____ <input type="checkbox"/> No Reason: _____	
4.												Date: _____ mm: _____	Date: _____ mm: _____	Date: _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	<input type="checkbox"/> Yes Date: _____ Drug (s) _____ <input type="checkbox"/> No Reason: _____	
5.												Date: _____ mm: _____	Date: _____ mm: _____	Date: _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	<input type="checkbox"/> Yes Date: _____ Drug (s) _____ <input type="checkbox"/> No Reason: _____	

***Exposure Category**

H= High
M= Medium
L= Low

****Prior Positive**

(1) = Follow-up needed
(2) = Follow-up not needed

*****Completion date or discontinued due to:**

(C) = Completed treatment
(D) = Died during treatment
(L) = Lost
(M) = Moved & Records Referred
(P) = Provider Discontinued Meds
(R) = Refused to continue
(T) = TB Disease Diagnosed



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